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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RICHARD BROOKS JUNG** P.O. Box 545 *Mendocino, California 95460* Registered Nurse License No. 518836 Respondent.	Case No. 2008-159 **ACCUSATION**

Ruth Ann Terry, M.P.H., R.N. ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about January 29, 1996, the Board issued Registered Nurse License Number 518836, to Richard Brooks Jung ("Respondent"). The license will expire on October 31, 2009, unless renewed.

JURISDICTION

3. Business and Professional Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a

temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750 of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

5. Code section 2761 states, in pertinent part:

"The Board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. Code section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(e) Falsify or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

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COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

9. "Meperidine Hydrochloride", a derivative of Pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(17).

FIRST CAUSE FOR DISCIPLINE

(Falsified, Made Incorrect or Inconsistent Entries In Hospital or Patient Records)

10. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct, as defined in Code section 2762(e), in that between August 10, 2002, and August 24, 2002, while employed as a registered nurse at Mendocino Coast District Hospital, Fort Bragg, California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records in the following respects:

Patient #1843978:

a. On or about August 10, 2002, at 1247 hours, Respondent signed out 100 mg. of injectable Meperidine, but failed to chart or otherwise account for the disposition of the medication. Furthermore, the signing out of the medication was inconsistent with physician's orders, which did not call for the administration of the medication.

Patient #1846674:

b. On or about August 20, 2002, at 0854 hours, Respondent signed out 100 mg. of injectable Meperidine, but failed to chart or otherwise account for the disposition of the medication. Furthermore, the signing out of the medication was inconsistent with physician's orders which, did not call for the administration of the medication.

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Patient #1846724:

c. On or about August 20, 2002, at 1234 hours, Respondent signed out 100 mg. of injectable Meperidine, charted the administration of 75 mg., but did not chart that he wasted the remaining 25 mg. of medication until 0356 hours, which is approximately 3 hours and 22 minutes after signing out the medication.

Patient #1847359:

d. On or about August 23, 2002, at 1011 hours, Respondent signed out 100 mg. of injectable Meperidine, charted the administration of 75 mg., but did not chart that he wasted the remaining 25 mg. of medication until 1742 hours, which is approximately 7 hours and 31 minutes after signing out the medication.

Patient #1847508:

e. On or about August 23, 2002, at 1558 hours, Respondent signed out 100 mg. of injectable Meperidine, charted the administration of 25 mg., but did not chart that he wasted the remaining 75 mg. of medication until 1741 hours, which is approximately 1 hour and 43 minutes after signing out the medication.

Patient #1848852:

f. On or about August 29, 2002, at 1042 hours, Respondent signed out 100 mg. of injectable Meperidine, charted the administration of 75 mg., but did not chart that he wasted the remaining 25 mg. of medication until 1153 hours, which is approximately 1 hour and 11 minutes after signing out the medication.

Patient #1848910:

g. On or about August 29, 2002, at 1309 hours, Respondent signed out 100 mg. of injectable Meperidine, charted the administration of 50 mg., but did not chart that he wasted the remaining 50 mg. of medication until 1912 hours, which is approximately 6 hours and 3 minutes after signing out the medication.

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Patient #1849132:

h. On or about August 29, 2002, at 1251 hours, Respondent signed out 100 mg. of injectable Meperidine, charted the administration of 50 mg., but did not chart that he wasted the remaining 50 mg. of medication until 1447 hours, which is approximately 1 hour and 5 minutes after signing out the medication.

Patient #1841949:

i. On or about August 3, 2002, at 0259 hours, Respondent signed out 100 mg. of injectable Meperidine, charted the administration of 50 mg., but did not chart that he wasted the remaining 50 mg. of medication until 0710 hours, which is approximately 4 hours and 11 minutes after signing out the medication.

Patient #1842921:

j. On or about August 6, 2002, at 1541 hours, Respondent signed out 100 mg. of injectable Meperidine, charted the administration of 50 mg., but did not chart that he wasted the remaining 50 mg. of medication until 1753 hours, which is approximately 2 hours and 12 minutes after signing out the medication.

Patient #1844117:

k. On or about August 10, 2002, at 0824 hours, Respondent signed out 100 mg. of injectable Meperidine, charted the administration of 50 mg., but failed to account for the disposition of the remaining 50 mg. of medication in any hospital or patient record.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

11. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2761(a)(1), in that, while employed as a registered nurse at Mendocino Coast District Hospital, Fort Bragg, California, Respondent was grossly negligent in the following respects:

a. On or about August 10, 2002, and August 20, 2002, Respondent withdrew excessive amounts of Meperidine, a controlled substance, without a physician order.

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b. Between August 3, 2002, and August 29, 2002, Respondent failed to properly waste excess controlled substances.

c. Between August 3, 2002, and August 29, 2002, Respondent failed to maintain custody and control of controlled substances he withdrew.

d. On or about August 20, 2002, Respondent tampered with a controlled substance syringe by removing an unknown quantity of Meperidine from the syringe, and diluting the remaining contents with saline solution.

e. On or about August 30, 2002, Respondent tampered with a controlled substance syringe by removing a seal from the syringe and replacing the entire dosage with saline solution.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 518836, issued to Richard Brooks Jung;

2. Ordering Richard Brooks Jung to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such order and further action as deemed necessary and proper.

DATED: 11/14/07

Mark Hochberg for
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

Accusation (kdg) 10/19/07
SF2006400026